MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (x) HCP ( ) IE ( ) IC	**Response Timely Filed?** () Yes (x) No
Requestor's Name and Address Wol + Med, Ed. Wolski, M.D. 2436 IH- 35 East South, Ste. 336 Denton TX 75205	MDR Tracking No.: M4-03-7674-01 TWCC No.: Injured Employee's Name:
Respondent's Name and Address BOX #: 47 American Casualty Co. c/o Gallagher Bassett PO Box 23812 Tuson AZ 85734	Date of Injury: Employer's Name: Thyssenkrupp Elevator Corp. Insurance Carrier's No.: 011508010245WC01

PART II: SUMMARY OF DISPUTE AND FINDINGS (Details on Page 2, if needed)

Dates of Service		**CPT Code(s) or Description**	**Amount in Dispute**	**Amount Due**
From	**To**			
10/8/02	**10/26/02**	**97139-PH x x 5**	**$37.50**	**$0.00**

PART III: REQUESTOR'S POSITION SUMMARY

7/7/03: "Our Position: All the DOS in this dispute were denied stating "00663 TED according to state fee schedule guidelines." This is not a correct payment exception code. If the carrier means "F" fee guidelines, then they have used the incorrect PEC code as 97139 –PH has no MAR…"

PART IV: RESPONDENT'S POSITION SUMMARY

NO RESPONSE RECEIVED

PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

- Original disputed DOS were from 10/8/02 through 11/18/02. On 6/27/03, the requestor faxed in an up-dated 'Table of Disputed Services' indicating payment received for DOS: 10/10/02, 10/15/02, 10/17/02, 10/19/02, 10/22/01, 10/29/02, 11,4/02, 11/7/02 and 11/18/02. The requestor did not submit a copy of an updated EOB therefore, unknown how respondent continued to deny the remaining DOS.
- CPT code 97139-PH, for DOS 10/8/02, 10/24/02, 10/26/02, 10/31/02 and 11/12/02 were originally denied with statement "TED according to state fee schedule guidelines." Due to the MFG descriptor for this CPT code indicating payment is DOP, the denial by the respondent is incorrectly denied. Per Rule 133.304(c) and MFG/GI (III)(A), SOAP notes/ documentation received from the requestor supports services rendered. The requestor did not submit convincing documentation that they billed with their usual and customary rates per rule 133.1 (a)(8), therefore reimbursement can not be recommended.

PART VI: COMMISSION DECISION AND ORDER

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is not entitled to additional reimbursement.

Ordered by:

		4/15/05
Authorized Signature	Name	Date of Order

PART VII: YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings/Appeals Clerk within 20 (twenty) days of your receipt of this decision (28 Texas Administrative Code § 148.3). This Decision was mailed to the health care provider and placed in the Austin Representatives box on _____. This Decision is deemed received by you five days after it was mailed and the first working day after the date the Decision was placed in the Austin Representative's box (28 Texas Administrative Code § 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, 7551 Metro Center Drive, Suite #100, Austin, Texas, 78744 or faxed to (512) 804-4011. A copy of this Decision should be attached to the request.

The party appealing the Division's Decision shall deliver a copy of their written request for a hearing to the opposing party involved in the dispute.

Si prefiere hablar con una persona in español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

PART IX: INSURANCE CARRIER DELIVERY CERTIFICATION

I hereby verify that I received a copy of this Decision and Order in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____